



**DARTMOUTH GENERAL HOSPITAL AUXILIARY**  
**VOLUNTEER APPLICATION AND REGISTRATION**  
(Auxiliary members must be over 18)

Thank you for applying to join the men and women of the Dartmouth General Hospital Auxiliary. The Auxiliary began in 1973 and since its inception has donated approximately \$ 1.72 million dollars to the Dartmouth General Hospital. Our motto is “to improve patient comfort at D.G.H.” The Auxiliary is run by an Executive and several Committees chaired by our active volunteers. There are approximately 134 members in our Auxiliary and we raise money through our very successful Gift Shoppe and other fundraising events. We conduct four General Membership Meetings a year in the Hospital Cafeteria in September, November, February and April, and our Annual General Meeting in May.

The annual membership dues are \$5, payable when you become a member and each year thereafter before the 30th of April. You are required to purchase and wear an auxiliary smock (cost is \$20) and a picture ID whenever you volunteer at DGH. Also, you must undergo a Criminal Record Check prior to being employed as a Dartmouth General Hospital Auxiliary Volunteer.

**TELL US ABOUT YOURSELF**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date \_\_\_\_\_

Your Home Address \_\_\_\_\_

Postal Code \_\_\_\_\_ Your Email Address \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

**Employment and Educational Experience: Please indicate your employment status:**

Employed                       Retired                       Other (Please specify)

**Please indicate if you are any of the following:**

High School Student                       Post Secondary (College, University, Trade School)

ESL (English as a Second language) Please identify any additional languages that you speak and/or write fluently \_\_\_\_\_.

**SKILLS: Please list what types of training or skills you have;**

<input type="checkbox"/> Computer Skills	<input type="checkbox"/> Hospitality/Customer Service	<input type="checkbox"/> Gardening
<input type="checkbox"/> Retail/Sales	<input type="checkbox"/> Visiting Volunteering	<input type="checkbox"/> Recreation/Games
<input type="checkbox"/> Other (Specify)		

**Membership in Clubs, Hobbies, Volunteer Experiences, Training:**

**Do you have any physical or health limitations that may prevent you from performing any specific volunteer role?**

NO                       Yes (Please List) \_\_\_\_\_

**Volunteer Commitment**

Tell us why you would like to join the Dartmouth General Hospital Auxiliary:

**The majority of volunteer programs require a commitment of six months or longer. Please indicate your commitment:**

Six months                       Longer than six months

**When are you available to volunteer at Dartmouth General Hospital? (Circle to Indicate Days/Times please):**

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM	AM	AM	AM	AM	AM	AM
PM	PM	PM	PM	PM	PM	PM
Evening	Evening	Evening	Evening	Evening	Evening	Evening

**What volunteer Jobs(s) would you like to do? (Check off your choices)**

<input type="checkbox"/> Gift Shoppe	<input type="checkbox"/> Night Lunches (evening hours)
<input type="checkbox"/> Gift Shoppe Cart	<input type="checkbox"/> Friendly Visitor Volunteer
<input type="checkbox"/> Information Desk/Lobby	<input type="checkbox"/> Diagnostic Imaging (Tues. & Fri.)
<input type="checkbox"/> Information Desk/ Emergency Department	<input type="checkbox"/> Pre-admission Clinic/ Day Surgery
<input type="checkbox"/> Menu Delivery (afternoon hours)	<input type="checkbox"/> Library

**References**

Please give the names and contact information of two (2) references that know your qualifications (Not Family members or Friends!) (Note: If you are not being referred by an Auxiliary member, your references will be contacted):

Auxiliary Member who is referring you \_\_\_\_\_

**Reference #1**

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Relationship \_\_\_\_\_

**Reference #2**

Name \_\_\_\_\_

Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Emergency Contact**

In an emergency we should contact:

1) Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

2) Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

You may drop your completed application form off at the Auxiliary Gift Shoppe or the front desk of the Hospital or mail it to: Membership, Dartmouth General Hospital Auxiliary, 325 Pleasant Street, Dartmouth, NS, B2Y 4G8.

Your signature below indicates that you have given accurate information about yourself and that you agree with the DGH Auxiliary’s privacy policy which states that “any information that you as a volunteer may gain about a fellow volunteer, hospital staff, a patient or a patient’s family will not in any way be disclosed by you and you understand that such disclosure will result in your termination as a volunteer at Dartmouth General Hospital”.

My signature: \_\_\_\_\_ Date: \_\_\_\_\_

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OFFICE USE:

Date interviewed: \_\_\_\_\_ Placement: \_\_\_\_\_

Comments: \_\_\_\_\_ Interviewed By: \_\_\_\_\_